KANSAS DEPARTMENT FOR AGING & DISABILITY SERVICES
Health Occupations Credentialing
APPLICATION FOR KANSAS DIETITIAN LICENSE

Circle type of license. Enclose non-refundable fee: Check or Money Order payable to KDADS.

Temporary: $70.00 Full: $140.00 Reciprocal: $140.00

**See attached fee schedule. Fees are pro-rated for partial year licenses. Personal checks are accepted; license may be subject to action if checks are found to invalid or insufficient funds.
Discover Card may be used for payment of fees. Charge authorization form must be completed and signed.

Applicant Information

Name: _____
Last First Mi Other

Address: _____
Street / Route / Box / Apt # City State Zip

Phone: work (____)_____ home (____) _____ Birthdate: ___ / ___ /___ SSN _____
(*attach a copy of your Social Security Card or document bearing your name and Social Security number*)

Education- List

	College/University	Degree	Date Conferred
1.			
2.			
3.			
4.			

•Transcripts must be sent by the college/university directly to Health Occupations Credentialing.
• The college/university must be regionally accredited by the United States Department of Education with the American Dietetics Association (ADA) approved program. If you hold a degree or completed course work from a non-accredited institution, you must complete Supplement A. (*request from the department*)
•Degrees or transcripts received from schools outside the United States or it's territories must be translated and/or evaluated by a validating agency.

Dietetic Experience

I have satisfactorily completed a 900 clock hour supervised dietetic experience. (May include Coordinated Undergraduate Program (CUP)), internship, preprofessional practice program, or other ADA approved training program or a program deemed equivalent by the Secretary of Health and Environment.

Facility: (College or Institution) _____

Address: _____

Supervisor: _____ Date Completed: _____

•Enclose documentation of completion of approved ADA supervised dietetic experience or submit a copy of your Commission on Dietetic Registration (CDR) card.
•If applicant had not completed an approved ADA dietetic experience, request, complete, and submit Supplement B. (*request from the department*)

Test Requirement

Check all that apply:

_____ I am applying for a full license with a fee of $140.00. A copy of my CDR card is enclosed.

_____ I am applying for a temporary license with a fee of $70.00. I am scheduled to take the CDR test and I will send a copy of my score report when I receive it.

_____ I am applying for a full license with a fee of $140.00. I am scheduled to take the CDR test and I will send a copy of my score report when I receive it.

License in Another State

List all states in which you have ever held a dietitian license:

State: _____ State: _____ State: _____

State: _____ State: _____ State: _____

For each state, complete Part I of the *Verification of License*, request that the state board complete Part II and return verification to KDADS.

Disciplinary Action

• This information is required under Kansas law: *KSA 65-3503(a)*

Has any license, certification, or registration issued by Kansas or another state or entity been denied, refused for renewal, suspended, revoked or subjected to any other disciplinary action? **Y / N**

If YES, please explain:

_____

_____

_____

_____

Have you ever been convicted of a crime by any court (including Kansas), or any federal court of the United States? **Y / N**

If YES, please indicate:

Date of conviction: _____

City, County and State of conviction: _____

Crime of which convicted: _____

I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the board to verify any information provided in this application and attachments. I understand that the application fee is non-refundable should I not meet licensure qualifications.

☞ **NOTE: Applicant's signature MUST be notarized**

I, _____, _____

(Applicant's Signature) *(Date)*

NOTARIZATION BOX

SUBSCRIBED AND SWORN TO before me, the undersigned authority, on this _____ day of _____, 201_____.

_____

(Notary Public)

My appointment expires_____.

Submit application, fee and supporting documents to:

Health Occupations Credentialing
Kansas Department for Aging & Disability Services
612 **S Kansas Ave**
Topeka, Kansas 66603